American Dental Association
www.ada.org

211 East Chicago Avenue
Chicago, Illinois 60611-2678
312-440-2699

Department of
Membership
Information

GRADUATE STUDENT MEMBERSHIP APPLICATION

Graduate student membership is available in the American Dental Association to any dentist who is engaged full-time in a residency or advanced education program of not less than one academic year's duration.

Please complete all sections of this application. Please print or type the information.

PERSONAL INFORMATION

ADA ID Number _____ SSN _____ Date of Birth ___/___/___ (MM DD YYYY)

Name _____ (First Last Middle) ☐ Male ☐ Female

Mailing Address _____ Is spouse a dentist? ☐ yes ☐ no

City _____ Daytime Phone (____) _____

State/Zip _____ Fax (____) _____ E-Mail Address _____

Spouse's name _____ Is this address your: ☐ home ☐ office

BRANCH OF SERVICE/VERIFICATION OF SERVICE

Are you in the Federal Dental Service? ☐ Yes ☐ No If yes, please check your branch of service below

☐ U.S. Air Force ☐ U.S. Army ☐ U.S. Navy ☐ U.S. Public Health Service ☐ U.S. Civil Service ☐ Veterans Affairs

Verification of Service *Please attach a photocopy of your federal I.D.* ☐ Federal I.D. Enclosed In-Service Date ___/___/___ (MM DD YYYY)

PREVIOUS EDUCATION

Dental School _____ Graduation Date ___/___/___ (MM DD YYYY)

☐ Copy of dental school diploma enclosed

Country of Dental School _____

Previous Advanced Education Program _____ (school/hospital city/state country)

Specialty Please check one: Graduation Date ___/___/___ (MM DD YYYY) Degree _____

☐ Endo. ☐ Ped. Dent. ☐ Perio. ☐ Public Health ☐ Prostho. ☐ Ortho. ☐ Oral Path. ☐ Oral Surg. ☐ Oral & Max. Rad. ☐ Other _____

CURRENT ADVANCED EDUCATION PROGRAM

School/Hospital _____ City/State _____ Country _____

_____ (Address)

Specialty Please check one:

☐ Endo. ☐ Ped. Dent. ☐ Perio. ☐ Public Health ☐ Prostho. ☐ Ortho. ☐ Oral Path. ☐ Oral Surg. ☐ Oral & Max. Rad. ☐ Other _____

Is this program a ☐ Dental Program ☐ Medical School ☐ Other _____

Program Start Date ___/___/___ (MM DD YYYY) **Completion Date** ___/___/___ (MM DD YYYY)

Do you have a U.S. License ☐ Yes ☐ No State of license _____ License number _____

PROGRAM VERIFICATION/REGISTRAR'S STAMP ***IMPORTANT: This section MUST be completed before your application can be processed.***

This is to verify that the above dentist is currently enrolled full-time in the above advanced education program.

Signed _____ (Dean's Signature or Registrar's Stamp Here) Program Start Date ___/___/___ (MM DD YYYY)

PAYMENT

Graduate Student Membership dues are $30.00.

☐ Enclosed is my check for membership dues ☐ $30.00 is enclosed for the 2003 membership year.

☐ Please charge my dues to the following: ☐ Visa ☐ MasterCard ☐ American Express

Card # _____ Expiration Date ___/___/___ (MM DD YYYY)

Signature _____

APPLICANT SIGNATURE

I hereby apply for graduate student membership in the American Dental Association and resolve to abide by the *Bylaws* and the *Code of Ethics and Professional Conduct* if accepted into membership.

Signed _____ Date _____

Membership in the American Dental Association is based on a calendar year from January to December. There is no charge for student member's subscription to *The Journal of the American Dental Association* and the *ADA News*.

Dues payments and contributions are not deductible as charitable contributions for federal income tax purposes to the extent that payments are not made to 501(c)(3) organizations. Only that portion of an association member's dues not attributable to lobbying activities is deductible as an ordinary and necessary business expense. For 2003, $2.00 of American Dental Association Graduate Student dues of $30.00 is allocable to lobbying and is not deductible as a business expense.

Rev. 11/02